This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1310	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 11:31 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 11:31 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MENDOTA COMMUNITY HOSPITAL (14-1310) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-488,626	-907,982	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-200,302	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,183,255		0	10.00
200.00	Total	0	-688,928	275,273	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 11:30 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 EAST 12TH ST	PO Box:			1.00
2.00	City: MENDOTA	State: IL	Zip Code: 61342-9216	County: LA SALLE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:30 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:30 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 11:30 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-1310	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:30 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 11:30 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	627,887	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 11:30 am

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 00131	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	Y	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 11:30 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/29/2018	Y	01/29/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 11:30 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544		PRACHELL@BKD.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-1310	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 11:30 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 11:30 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	26,328.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	26,328.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	336.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	26,664.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 11:30 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	703	172	1,097			1.00
2.00	HMO and other (see instructions)	129	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	720	0	974			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	102			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,423	172	2,173			7.00
8.00	INTENSIVE CARE UNIT	4	0	14			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,427	172	2,187	0.00	159.43	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	6,533	3,600	18,353	0.00	35.36	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	194.79	27.00
28.00	Observation Bed Days		0	475			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 11:30 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	225	56	379	1.00
2.00	HMO and other (see instructions)			32	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	225	56	379	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-8 | Date/Time Prepared: 2/26/2018 11:30 am

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			1405 E. 12TH ST.		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MENDOTA		IL	61342	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00
		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y	2	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number			MENDOTA COMMUNITY HOSPITAL - RHC		148535	14.00
14.01				OSF MEDICAL GROUP WASHINGTON STREET		148567	14.01
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
			County				
			4.00				
2.00	City, State, ZIP Code, County		LASALLE COUNTY				2.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1310
Component CCN: 14-8535

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-8

Date/Time Prepared:
2/26/2018 11:30 am

RHC I | Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/26/2018 11:30 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.430745	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,760,959	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	794,250	6.00
7.00	Medicaid cost (line 1 times line 6)	342,119	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,101,743	76,820	1,178,563	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	474,570	76,820	551,390	21.00
22.00	Payments received from patients for amounts previously written off as charity care	12,713	9,352	22,065	22.00
23.00	Cost of charity care (line 21 minus line 22)	461,857	67,468	529,325	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,019,696	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	456,218	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	701,874	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	317,822	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	382,556	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	911,881	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	911,881	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,039,098	1,039,098	1,746,381	2,785,479	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0	0	128	128	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		827,019	827,019	-81,986	745,033	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,872	3,768,938	3,758,066	-29,095	3,728,971	4.00
5.01	01140	BUSINESS OFFICE	283,120	907,522	1,190,642	0	1,190,642	5.01
5.02	00550	DATA PROCESSING	0	1,420,399	1,420,399	0	1,420,399	5.02
5.03	00570	ADMITTING	0	0	0	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	106,540	144,987	251,527	0	251,527	5.04
5.05	00590	OTHER A&G	918,781	2,336,618	3,255,399	-108,374	3,147,025	5.05
7.00	00700	OPERATION OF PLANT	294,835	663,265	958,100	29,051	987,151	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,461	67,461	0	67,461	8.00
9.00	00900	HOUSEKEEPING	338,144	35,753	373,897	0	373,897	9.00
10.00	01000	DIETARY	279,768	121,938	401,706	-295,674	106,032	10.00
11.00	01100	CAFETERIA	0	0	0	295,674	295,674	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	59,799	59,799	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	256,907	14,969	271,876	0	271,876	16.00
17.00	01700	SOCIAL SERVICE	-2,708	223,601	220,893	0	220,893	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,329,886	184,411	1,514,297	4,320	1,518,617	30.00
31.00	03100	INTENSIVE CARE UNIT	24,059	18,049	42,108	718	42,826	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	373,410	377,348	750,758	-30,412	720,346	50.00
51.00	05100	RECOVERY ROOM	252,200	21,731	273,931	222	274,153	51.00
53.00	05300	ANESTHESIOLOGY	441,489	33,607	475,096	451	475,547	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	790,982	948,543	1,739,525	-519,235	1,220,290	54.00
56.00	05600	RADIOISOTOPE	0	276,573	276,573	-34,329	242,244	56.00
57.00	05700	CT SCAN	0	10,496	10,496	220,354	230,850	57.00
58.00	05800	MRI	0	8,803	8,803	105,614	114,417	58.00
60.00	06000	LABORATORY	664,495	571,624	1,236,119	46,067	1,282,186	60.00
64.00	06400	INTRAVENOUS THERAPY	338,382	23,773	362,155	-1,300	360,855	64.00
65.00	06500	RESPIRATORY THERAPY	386,314	34,361	420,675	4,657	425,332	65.00
66.00	06600	PHYSICAL THERAPY	500,539	30,441	530,980	2,175	533,155	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,199	75,569	186,768	0	186,768	67.00
68.00	06800	SPEECH PATHOLOGY	62,790	6,634	69,424	0	69,424	68.00
69.00	06900	ELECTROCARDIOLOGY	88,604	19,653	108,257	25,899	134,156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,748	-43,872	-7,124	79,352	72,228	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	222,454	2,077,876	2,300,330	236,011	2,536,341	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,778,619	1,728,527	4,507,146	-642,607	3,864,539	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,013,659	2,303,163	3,316,822	4,648	3,321,470	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,467,851	1,467,851	-1,467,851	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,880,344	21,746,729	33,627,073	-349,342	33,277,731	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,888	38,888	0	38,888	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	37,789	30,163	67,952	349,342	417,294	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	213,571	213,571	0	213,571	194.01
194.02	07952	FOUNDATION	0	22,205	22,205	0	22,205	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	11,918,133	22,051,556	33,969,689	0	33,969,689	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-362,207	2,423,272		1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	128		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	550,254	1,295,287		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-700,840	3,028,131		4.00
5.01	01140	BUSINESS OFFICE	-715,826	474,816		5.01
5.02	00550	DATA PROCESSING	-1,089,153	331,246		5.02
5.03	00570	ADMITTING	0	0		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	-52,726	198,801		5.04
5.05	00590	OTHER A&G	2,333,895	5,480,920		5.05
7.00	00700	OPERATION OF PLANT	-79,159	907,992		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	67,461		8.00
9.00	00900	HOUSEKEEPING	0	373,897		9.00
10.00	01000	DIETARY	0	106,032		10.00
11.00	01100	CAFETERIA	-81,404	214,270		11.00
13.00	01300	NURSING ADMINISTRATION	145,171	204,970		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,025	265,851		16.00
17.00	01700	SOCIAL SERVICE	-51,302	169,591		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-46,875	1,471,742		30.00
31.00	03100	INTENSIVE CARE UNIT	0	42,826		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	720,346		50.00
51.00	05100	RECOVERY ROOM	0	274,153		51.00
53.00	05300	ANESTHESIOLOGY	-441,489	34,058		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,220,290		54.00
56.00	05600	RADIOISOTOPE	0	242,244		56.00
57.00	05700	CT SCAN	0	230,850		57.00
58.00	05800	MRI	0	114,417		58.00
60.00	06000	LABORATORY	-3,450	1,278,736		60.00
64.00	06400	INTRAVENOUS THERAPY	0	360,855		64.00
65.00	06500	RESPIRATORY THERAPY	0	425,332		65.00
66.00	06600	PHYSICAL THERAPY	-1,625	531,530		66.00
67.00	06700	OCCUPATIONAL THERAPY	-72,240	114,528		67.00
68.00	06800	SPEECH PATHOLOGY	-33,652	35,772		68.00
69.00	06900	ELECTROCARDIOLOGY	-9,177	124,979		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	72,228		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-123,460	2,412,881		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-53,173	3,811,366		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,587,417	1,734,053		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,481,880	30,795,851		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,888		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	417,294		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	MARKETING	-213,571	0		194.01
194.02	07952	FOUNDATION	0	22,205		194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,695,451	31,274,238		200.00

RECLASSIFICATIONS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 11:30 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,460,436	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,415	2.00
	0		0	1,467,851	
	B - TO RECLASS COPIER LEASE EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	19,382	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	19,382	
	D - TO RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	205,922	89,752	1.00
	0		205,922	89,752	
	E - TO RECLASS OFFSITE CLINIC EXPENSE				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25,949	1.00
2.00	RURAL HEALTH CLINIC	88.00	0	11,599	2.00
	0		0	37,548	
	G - TO RECLASS PHY CLNC OFF EQPMT DPR				
1.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	128	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	108,655	2.00
	0		0	108,783	
	H - TO RECLASS PROPERTY INS EXP				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	149,863	1.00
	0		0	149,863	
	I - TO RECLASS AUTO & OTHER PROP INSUR				
1.00	OTHER A&G	5.05	0	1,668	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27,427	2.00
	0		0	29,095	
	K - TO RECLASS IMPLANTS AND O2 EXP				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	73,205	1.00
2.00		0.00	0	0	2.00
	0		0	73,205	
	L - TO RECLASS DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	236,011	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	236,011	
	O - TO RECLLASS NURSING ADMIN EXP				
1.00	NURSING ADMINISTRATION	13.00	59,799	0	1.00
	0		59,799	0	
	V - PHYSICIAN ADMIN COSTS				
1.00	OTHER A&G	5.05	144,350	0	1.00
	TOTALS		144,350	0	
	W - TO RECLASS RADIOLOGY EXPENSES				
1.00	CT SCAN	57.00	177,364	42,990	1.00
2.00	MRI	58.00	92,536	12,351	2.00
3.00	ELECTROCARDIOLOGY	69.00	10,686	13,522	3.00
4.00	RADIOISOTOPE	56.00	5,343	5,066	4.00
	0		285,929	73,929	
	X - TELEPHONE EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	29,051	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	29,051	
	Y - CLINICAL ENGINEERING DEPT				
1.00	OTHER A&G	5.05	0	792	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	4,320	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	718	3.00
4.00	OPERATING ROOM	50.00	0	40,812	4.00
5.00	RECOVERY ROOM	51.00	0	222	5.00
6.00	ANESTHESIOLOGY	53.00	0	3,006	6.00
7.00	MRI	58.00	0	727	7.00
8.00	LABORATORY	60.00	0	65,071	8.00
9.00	INTRAVENOUS THERAPY	64.00	0	235	9.00
10.00	RESPIRATORY THERAPY	65.00	0	6,832	10.00
11.00	PHYSICAL THERAPY	66.00	0	2,175	11.00
12.00	ELECTROCARDIOLOGY	69.00	0	1,773	12.00
13.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,147	13.00
14.00	RURAL HEALTH CLINIC	88.00	0	1,304	14.00
15.00	EMERGENCY	91.00	0	4,648	15.00

RECLASSIFICATIONS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 11:30 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,442		16.00
	TOTALS		0	142,224		
	Z - RCL PORTION OF YR CLINIC WAS PHY OFF					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	195,476	126,059		1.00
	TOTALS		195,476	126,059		
500.00	Grand Total: Increases		891,476	2,582,753		500.00

RECLASSIFICATIONS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 11:30 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,467,851	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,467,851			
	B - TO RECLASS COPIER LEASE EXPENSE						
1.00	OTHER A&G	5.05	0	296	10		1.00
2.00	LABORATORY	60.00	0	19,004	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	82	0		3.00
	0		0	19,382			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	205,922	89,752	0		1.00
	0		205,922	89,752			
	E - TO RECLASS OFFSITE CLINIC EXPENSE						
1.00	OTHER A&G	5.05	0	37,548	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	37,548			
	G - TO RECLASS PHY CLNC OFF EQPMT DPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	108,783	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	108,783			
	H - TO RECLASS PROPERTY INS EXP						
1.00	OTHER A&G	5.05	0	149,863	14		1.00
	0		0	149,863			
	I - TO RECLASS AUTO & OTHER PROP INSUR						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29,095	0		1.00
2.00		0.00	0	0	14		2.00
	0		0	29,095			
	K - TO RECLASS IMPLANTS AND O2 EXP						
1.00	OPERATING ROOM	50.00	0	71,224	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	1,981	0		2.00
	0		0	73,205			
	L - TO RECLASS DRUGS						
1.00	ANESTHESIOLOGY	53.00	0	2,555	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,153	0		2.00
3.00	RADIOISOTOPE	56.00	0	44,738	0		3.00
4.00	INTRAVENOUS THERAPY	64.00	0	1,535	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	194	0		5.00
6.00	RURAL HEALTH CLINIC	88.00	0	169,836	0		6.00
	0		0	236,011			
	O - TO RECLLASS NURSING ADMIN EXP						
1.00	OTHER A&G	5.05	59,799	0	0		1.00
	0		59,799	0			
	V - PHYSICIAN ADMIN COSTS						
1.00	RURAL HEALTH CLINIC	88.00	144,350	0	0		1.00
	TOTALS		144,350	0			
	W - TO RECLASS RADIOLOGY EXPENSES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	285,929	73,929	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		285,929	73,929			
	X - TELEPHONE EXPENSE						
1.00	OTHER A&G	5.05	0	7,678	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	19,789	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,584	0		3.00
	0		0	29,051			
	Y - CLINICAL ENGINEERING DEPT						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	142,224	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	TOTALS		0	142,224			

RECLASSIFICATIONS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 11:30 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	Z - RCL PORTION OF YR CLINIC WAS PHY OFF						
1.00	RURAL HEALTH CLINIC	88.00	195,476	126,059	0		1.00
	TOTALS		195,476	126,059			
500.00	Grand Total: Decreases		891,476	2,582,753			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2018 11:30 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,927,000	0	0	0	0	1.00
2.00	Land Improvements	2,405,200	238,398	0	238,398	0	2.00
3.00	Buildings and Fixtures	17,332,299	766,973	0	766,973	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,380,376	0	0	0	4,380,376	5.00
6.00	Movable Equipment	11,153,470	5,132,895	0	5,132,895	27,346	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,198,345	6,138,266	0	6,138,266	4,407,722	8.00
9.00	Reconciling Items	0	25,830	0	25,830	0	9.00
10.00	Total (line 8 minus line 9)	37,198,345	6,112,436	0	6,112,436	4,407,722	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,927,000	0	1.00
2.00	Land Improvements	2,643,598	0	2.00
3.00	Buildings and Fixtures	18,099,272	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	16,259,019	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,928,889	0	8.00
9.00	Reconciling Items	25,830	0	9.00
10.00	Total (line 8 minus line 9)	38,903,059	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2018 11:30 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,039,098	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	827,019	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,866,117	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,039,098	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	827,019	2.00
3.00	Total (sum of lines 1-2)	0	1,866,117	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2018 11:30 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	22,667,630	0	22,667,630	0.582283	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	2,240	0	2,240	0.000058	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	16,259,019	0	16,259,019	0.417659	0	2.00
3.00	Total (sum of lines 1-2)	38,928,889	0	38,928,889	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	846,354	-45,340	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	128	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,268,569	19,382	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,115,051	-25,958	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,444,968	0	0	177,290	2,423,272	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	128	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	7,336	0	0	0	1,295,287	2.00
3.00	Total (sum of lines 1-2)	1,452,304	0	0	177,290	3,718,687	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 11:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-15,468	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-79	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-45,340	CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,155,980			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	422,270			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-79,790	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,025	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,614	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-OFFSITE MOBS		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 11:30 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-7,787	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-70	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-1,832	OTHER A&G	5.05	0	33.01
33.02	MISCELLANEOUS INCOME	B	-1,625	PHYSICAL THERAPY	66.00	0	33.02
33.03	MISCELLANEOUS INCOME	B	-33,652	SPEECH PATHOLOGY	68.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-4,668	ELECTROCARDIOLOGY	69.00	0	33.04
33.05	MISCELLANEOUS INCOME	B	-44,532	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	MISCELLANEOUS INCOME	B	-20,844	OTHER A&G	5.05	0	33.06
33.07	CABLE TV EXPENSE	A	-2,912	OTHER A&G	5.05	0	33.07
33.08	INCOME TAXES	A	-1,911	OTHER A&G	5.05	0	33.08
33.09	MOB PROPERTY TAXES	A	-29,337	OTHER A&G	5.05	0	33.09
33.10	COMMUNITY HEALTH EXPENSE	A	-22,516	OTHER A&G	5.05	0	33.10
33.11	COMMUNITY HEALTH BENEFIT EXPENSE	A	-6,862	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	LOBBYING EXPENSE	A	-14,806	OTHER A&G	5.05	0	33.12
33.13	CRNA BENEFIT EXPENSE	A	-44,328	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	PROVIDER TAX IDPA EXPENSE	A	-547,189	OTHER A&G	5.05	0	33.14
33.15	LEGAL EXPENSE ADJUSTMENT	A	-19,913	OTHER A&G	5.05	0	33.15
33.16	ALCOHOL EXPENSES	A	-184	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	MOONLIGHTING RESIDENT SAL EXP	A	-8,457	RURAL HEALTH CLINIC	88.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,695,451				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 11:30 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	92,355	393,754	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	558,120	0	2.00
3.00	5.05	OTHER A&G	A&G HO MANAGEMENT	2,936,804	1,257,929	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	0	649,580	3.01
3.02	5.01	BUSINESS OFFICE	MINISTRY ALLOCATION	0	715,826	3.02
4.00	5.02	DATA PROCESSING	MINISTRY ALLOCATION	0	1,089,153	4.00
4.01	5.04	PURCHASING RECEIVING AND STO	MINISTRY ALLOCATION	0	52,726	4.01
4.02	5.05	OTHER A&G	MINISTRY ALLOCATION	1,316,280	0	4.02
4.03	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	0	79,159	4.03
4.04	13.00	NURSING ADMINISTRATION	MINISTRY ALLOCATION	145,171	0	4.04
4.05	17.00	SOCIAL SERVICE	MINISTRY ALLOCATION	172,005	223,307	4.05
4.06	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	0	123,460	4.06
4.07	194.01	MARKETING	MINISTRY ALLOCATION	0	213,571	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5,220,735	4,798,465	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 11:30 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-301,399	9		1.00
2.00	558,120	9		2.00
3.00	1,678,875	0		3.00
3.01	-649,580	0		3.01
3.02	-715,826	0		3.02
4.00	-1,089,153	0		4.00
4.01	-52,726	0		4.01
4.02	1,316,280	0		4.02
4.03	-79,159	0		4.03
4.04	145,171	0		4.04
4.05	-51,302	0		4.05
4.06	-123,460	0		4.06
4.07	-213,571	0		4.07
5.00	422,270			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2018 11:30 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER A&G	144,350	0	144,350	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	46,875	46,875	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	441,489	441,489	0	0	0	3.00
4.00	60.00	LABORATORY	16,820	3,450	13,370	0	0	4.00
5.00	67.00	OCCUPATIONAL THERAPY	72,240	72,240	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	4,509	4,509	0	0	0	6.00
7.00	91.00	EMERGENCY	2,028,389	1,587,417	440,972	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,754,672	2,155,980	598,692		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.05	OTHER A&G	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.05	OTHER A&G	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	46,875		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	441,489		3.00
4.00	60.00	LABORATORY	0	0	0	3,450		4.00
5.00	67.00	OCCUPATIONAL THERAPY	0	0	0	72,240		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	4,509		6.00
7.00	91.00	EMERGENCY	0	0	0	1,587,417		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,155,980		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,423,272	2,423,272				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	128	0	128			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,295,287			1,295,287		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,028,131	3,418	0	1,827	3,033,376	4.00
5.01	01140	BUSINESS OFFICE	474,816	32,243	0	17,235	74,940	5.01
5.02	00550	DATA PROCESSING	331,246	37,649	0	20,124	0	5.02
5.03	00570	ADMITTING	0	19,879	0	10,626	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	198,801	8,824	0	4,717	28,201	5.04
5.05	00590	OTHER A&G	5,480,920	471,938	0	252,255	259,788	5.05
7.00	00700	OPERATION OF PLANT	907,992	108,681	0	58,092	78,041	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,461	11,491	0	6,142	0	8.00
9.00	00900	HOUSEKEEPING	373,897	26,522	0	14,176	89,505	9.00
10.00	01000	DIETARY	106,032	65,965	0	35,260	19,547	10.00
11.00	01100	CAFETERIA	214,270	26,037	0	13,917	54,507	11.00
13.00	01300	NURSING ADMINISTRATION	204,970	8,606	0	4,600	15,828	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	265,851	21,503	0	11,494	68,002	16.00
17.00	01700	SOCIAL SERVICE	169,591	7,249	0	3,875	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,471,742	370,359	0	197,964	352,014	30.00
31.00	03100	INTENSIVE CARE UNIT	42,826	56,098	0	29,986	6,368	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	720,346	105,966	0	56,641	98,840	50.00
51.00	05100	RECOVERY ROOM	274,153	118,887	0	63,548	66,756	51.00
53.00	05300	ANESTHESIOLOGY	34,058	3,127	0	1,672	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,220,290	92,705	0	49,553	133,685	54.00
56.00	05600	RADIOISOTOPE	242,244	16,655	0	8,902	1,414	56.00
57.00	05700	CT SCAN	230,850	11,224	0	6,000	46,947	57.00
58.00	05800	MRI	114,417	25,140	0	13,438	24,494	58.00
60.00	06000	LABORATORY	1,278,736	46,013	0	24,595	175,889	60.00
64.00	06400	INTRAVENOUS THERAPY	360,855	108,899	0	58,209	89,568	64.00
65.00	06500	RESPIRATORY THERAPY	425,332	52,486	0	28,055	102,255	65.00
66.00	06600	PHYSICAL THERAPY	531,530	50,765	0	27,135	132,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,528	11,903	0	6,363	29,434	67.00
68.00	06800	SPEECH PATHOLOGY	35,772	2,449	0	1,309	16,620	68.00
69.00	06900	ELECTROCARDIOLOGY	124,979	2,473	0	1,322	26,282	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	72,228	67,807	0	36,244	9,727	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,412,881	19,176	0	10,250	58,882	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,811,366	186,210	0	99,533	643,298	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,734,053	119,954	0	64,118	268,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,795,851	2,318,301	0	1,239,177	2,971,632	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,888	5,867	0	3,136	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	417,294	96,244	128	51,444	61,744	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,430	0	765	0	194.01
194.02	07952	FOUNDATION	22,205	1,430	0	765	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,274,238	2,423,272	128	1,295,287	3,033,376	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	
			4A	5.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	599,234	599,234				5.01
5.02	00550	DATA PROCESSING	389,019	7,618	396,637			5.02
5.03	00570	ADMITTING	30,505	597	11,862	42,964	42,964	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	240,543	4,710	881	246,134	414	5.04
5.05	00590	OTHER A&G	6,464,901	126,612	25,318	6,616,831	11,129	5.05
7.00	00700	OPERATION OF PLANT	1,152,806	22,574	2,884	1,178,264	1,982	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,094	1,666	0	86,760	146	8.00
9.00	00900	HOUSEKEEPING	504,100	9,871	1,045	515,016	866	9.00
10.00	01000	DIETARY	226,804	4,441	979	232,224	391	10.00
11.00	01100	CAFETERIA	308,731	6,046	0	314,777	529	11.00
13.00	01300	NURSING ADMINISTRATION	234,004	4,582	0	238,586	401	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	366,850	7,184	46,180	420,214	707	16.00
17.00	01700	SOCIAL SERVICE	180,715	3,539	2,144	186,398	314	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,392,079	46,842	5,207	2,444,128	4,111	30.00
31.00	03100	INTENSIVE CARE UNIT	135,278	2,649	9,359	147,286	248	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	981,793	19,225	10,398	1,011,416	1,701	50.00
51.00	05100	RECOVERY ROOM	523,344	10,248	13,930	547,522	921	51.00
53.00	05300	ANESTHESIOLOGY	38,857	761	2,721	42,339	71	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,496,233	29,299	23,506	1,549,038	2,605	54.00
56.00	05600	RADIOISOTOPE	269,215	5,272	0	274,487	462	56.00
57.00	05700	CT SCAN	295,021	5,777	871	301,669	507	57.00
58.00	05800	MRI	177,489	3,476	0	180,965	304	58.00
60.00	06000	LABORATORY	1,525,233	29,867	1,948	1,557,048	2,619	60.00
64.00	06400	INTRAVENOUS THERAPY	617,531	12,092	2,285	631,908	1,063	64.00
65.00	06500	RESPIRATORY THERAPY	608,128	11,908	1,083	621,119	1,045	65.00
66.00	06600	PHYSICAL THERAPY	741,920	14,528	42,839	799,287	1,344	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,228	3,177	0	165,405	278	67.00
68.00	06800	SPEECH PATHOLOGY	56,150	1,100	2,449	59,699	100	68.00
69.00	06900	ELECTROCARDIOLOGY	155,056	3,036	854	158,946	267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,006	3,642	490	190,138	320	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,501,189	48,978	47,045	2,597,212	4,369	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,740,407	92,827	140,305	4,973,539	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,186,435	42,815	0	2,229,250	3,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,572,898	586,959	396,583	30,560,569	42,964	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,891	0	0	47,891	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	626,854	12,275	0	639,129	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,195	0	54	2,249	0	194.01
194.02	07952	FOUNDATION	24,400	0	0	24,400	0	194.02
200.00		Cross Foot Adjustments	0			0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,274,238	599,234	396,637	31,274,238	42,964	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES	246,548					5.04
5.05	00590	OTHER A&G	6,691	6,634,651	6,634,651			5.05
7.00	00700	OPERATION OF PLANT	6,862	1,187,108	319,650	1,506,758		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,474	89,380	24,067	9,947	123,394	8.00
9.00	00900	HOUSEKEEPING	8,278	524,160	141,140	22,958	0	9.00
10.00	01000	DIETARY	3,726	236,341	63,639	57,102	0	10.00
11.00	01100	CAFETERIA	1,021	316,327	85,177	22,538	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	238,987	64,352	7,450	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	352	421,273	113,435	18,614	0	16.00
17.00	01700	SOCIAL SERVICE	61	186,773	50,292	6,275	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,560	2,464,799	663,691	320,594	34,778	30.00
31.00	03100	INTENSIVE CARE UNIT	308	147,842	39,809	48,560	238	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	68,351	1,081,468	291,205	91,728	13,127	50.00
51.00	05100	RECOVERY ROOM	3,643	552,086	148,659	102,913	6,007	51.00
53.00	05300	ANESTHESIOLOGY	4,795	47,205	12,711	2,707	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,860	1,557,503	419,386	80,249	9,389	54.00
56.00	05600	RADIOISOTOPE	0	274,949	74,035	14,417	1,687	56.00
57.00	05700	CT SCAN	2,910	305,086	82,150	9,716	1,137	57.00
58.00	05800	MRI	3,974	185,243	49,880	21,762	2,546	58.00
60.00	06000	LABORATORY	27,345	1,587,012	427,332	39,830	0	60.00
64.00	06400	INTRAVENOUS THERAPY	5,126	638,097	171,819	94,267	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,828	628,992	169,367	45,434	1,603	65.00
66.00	06600	PHYSICAL THERAPY	2,393	803,024	216,229	43,944	11,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	199	165,882	44,667	10,304	2,742	67.00
68.00	06800	SPEECH PATHOLOGY	45	59,844	16,114	2,120	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,881	161,094	43,377	2,141	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	200	190,658	51,338	58,696	55	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,039	2,606,620	701,879	16,600	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,742	5,007,281	1,348,299	161,190	1,530	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	15,962	2,248,962	605,573	103,836	36,606	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	234,626	30,548,647	6,439,272	1,415,892	123,367	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,750	58,641	15,790	5,078	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,159	640,288	172,409	83,312	27	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,249	606	1,238	0	194.01
194.02	07952	FOUNDATION	13	24,413	6,574	1,238	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	246,548	31,274,238	6,634,651	1,506,758	123,394	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	688,258					9.00
10.00	01000	DIETARY	6,082	363,164				10.00
11.00	01100	CAFETERIA	16,873	0	440,915			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,149	311,938		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,905	0	16,835	0	575,062	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,117	333,515	80,231	101,113	202,440	30.00
31.00	03100	INTENSIVE CARE UNIT	10,006	1,346	932	1,170	278	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,795	0	18,792	23,677	0	50.00
51.00	05100	RECOVERY ROOM	14,715	7,145	14,040	17,704	39,487	51.00
53.00	05300	ANESTHESIOLOGY	0	0	6,243	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,904	0	23,234	29,290	26,973	54.00
56.00	05600	RADIOISOTOPE	6,474	0	155	201	4,727	56.00
57.00	05700	CT SCAN	4,316	0	8,759	11,042	3,337	57.00
58.00	05800	MRI	9,810	0	4,100	5,182	7,230	58.00
60.00	06000	LABORATORY	23,151	0	39,417	49,681	19,465	60.00
64.00	06400	INTRAVENOUS THERAPY	28,056	0	18,978	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,208	0	22,830	0	20,300	65.00
66.00	06600	PHYSICAL THERAPY	18,639	0	21,432	0	22,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,316	0	4,721	0	2,225	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,168	0	834	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,205	2,768	3,337	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,924	0	5,094	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,082	0	8,076	10,159	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	108,497	5,243	84,769	0	39,487	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	68,276	15,915	47,586	59,951	150,717	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	632,146	363,164	432,746	311,938	543,083	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	56,112	0	8,169	0	31,979	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	688,258	363,164	440,915	311,938	575,062	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	243,340					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	211,941	4,572,219	0	4,572,219		30.00
31.00	03100	INTENSIVE CARE UNIT	0	250,181	0	250,181		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,602,792	0	1,602,792		50.00
51.00	05100	RECOVERY ROOM	0	902,756	0	902,756		51.00
53.00	05300	ANESTHESIOLOGY	0	68,866	0	68,866		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,181,928	0	2,181,928		54.00
56.00	05600	RADIOISOTOPE	0	376,645	0	376,645		56.00
57.00	05700	CT SCAN	0	425,543	0	425,543		57.00
58.00	05800	MRI	0	285,753	0	285,753		58.00
60.00	06000	LABORATORY	0	2,185,888	0	2,185,888		60.00
64.00	06400	INTRAVENOUS THERAPY	0	951,217	0	951,217		64.00
65.00	06500	RESPIRATORY THERAPY	0	908,734	0	908,734		65.00
66.00	06600	PHYSICAL THERAPY	0	1,137,436	0	1,137,436		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	234,857	0	234,857		67.00
68.00	06800	SPEECH PATHOLOGY	0	82,080	0	82,080		68.00
69.00	06900	ELECTROCARDIOLOGY	0	214,922	0	214,922		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	309,765	0	309,765		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,349,416	0	3,349,416		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,710	6,761,006	0	6,761,006		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	26,689	3,364,111	0	3,364,111		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	243,340	30,166,115	0	30,166,115		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	79,509	0	79,509		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	992,296	0	992,296		192.00
194.00	07950	OTHER NRCC	0	0	0	0		194.00
194.01	07951	MARKETING	0	4,093	0	4,093		194.01
194.02	07952	FOUNDATION	0	32,225	0	32,225		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	243,340	31,274,238	0	31,274,238		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS OFFSITE MOBS	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,418	0	1,827	5,245	4.00
5.01	01140	BUSINESS OFFICE	0	32,243	0	17,235	49,478	5.01
5.02	00550	DATA PROCESSING	0	37,649	0	20,124	57,773	5.02
5.03	00570	ADMITTING	0	19,879	0	10,626	30,505	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	8,824	0	4,717	13,541	5.04
5.05	00590	OTHER A&G	0	471,938	0	252,255	724,193	5.05
7.00	00700	OPERATION OF PLANT	0	108,681	0	58,092	166,773	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,491	0	6,142	17,633	8.00
9.00	00900	HOUSEKEEPING	0	26,522	0	14,176	40,698	9.00
10.00	01000	DIETARY	0	65,965	0	35,260	101,225	10.00
11.00	01100	CAFETERIA	0	26,037	0	13,917	39,954	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,606	0	4,600	13,206	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	21,503	0	11,494	32,997	16.00
17.00	01700	SOCIAL SERVICE	0	7,249	0	3,875	11,124	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	370,359	0	197,964	568,323	30.00
31.00	03100	INTENSIVE CARE UNIT	0	56,098	0	29,986	86,084	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	105,966	0	56,641	162,607	50.00
51.00	05100	RECOVERY ROOM	0	118,887	0	63,548	182,435	51.00
53.00	05300	ANESTHESIOLOGY	0	3,127	0	1,672	4,799	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	92,705	0	49,553	142,258	54.00
56.00	05600	RADIOISOTOPE	0	16,655	0	8,902	25,557	56.00
57.00	05700	CT SCAN	0	11,224	0	6,000	17,224	57.00
58.00	05800	MRI	0	25,140	0	13,438	38,578	58.00
60.00	06000	LABORATORY	0	46,013	0	24,595	70,608	60.00
64.00	06400	INTRAVENOUS THERAPY	0	108,899	0	58,209	167,108	64.00
65.00	06500	RESPIRATORY THERAPY	0	52,486	0	28,055	80,541	65.00
66.00	06600	PHYSICAL THERAPY	0	50,765	0	27,135	77,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,903	0	6,363	18,266	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,449	0	1,309	3,758	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,473	0	1,322	3,795	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	67,807	0	36,244	104,051	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,176	0	10,250	29,426	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	186,210	0	99,533	285,743	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	119,954	0	64,118	184,072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,318,301	0	1,239,177	3,557,478	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,867	0	3,136	9,003	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	96,244	128	51,444	147,816	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,430	0	765	2,195	194.01
194.02	07952	FOUNDATION	0	1,430	0	765	2,195	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,423,272	128	1,295,287	3,718,687	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,245					4.00
5.01	01140	BUSINESS OFFICE	130	49,608				5.01
5.02	00550	DATA PROCESSING	0	631	58,404			5.02
5.03	00570	ADMITTING	0	49	1,747	32,301		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	49	390	130	311	14,421	5.04
5.05	00590	OTHER A&G	450	10,486	3,728	8,356	391	5.05
7.00	00700	OPERATION OF PLANT	135	1,869	425	1,491	401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138	0	110	145	8.00
9.00	00900	HOUSEKEEPING	155	817	154	651	484	9.00
10.00	01000	DIETARY	34	368	144	294	218	10.00
11.00	01100	CAFETERIA	94	500	0	398	60	11.00
13.00	01300	NURSING ADMINISTRATION	27	379	0	302	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	118	595	6,800	532	21	16.00
17.00	01700	SOCIAL SERVICE	0	293	316	236	4	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	609	3,878	767	3,092	969	30.00
31.00	03100	INTENSIVE CARE UNIT	11	219	1,378	186	18	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	171	1,591	1,531	1,279	3,996	50.00
51.00	05100	RECOVERY ROOM	116	848	2,051	693	213	51.00
53.00	05300	ANESTHESIOLOGY	0	63	401	54	280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231	2,425	3,461	1,960	343	54.00
56.00	05600	RADIOISOTOPE	2	436	0	347	0	56.00
57.00	05700	CT SCAN	81	478	128	382	170	57.00
58.00	05800	MRI	42	288	0	229	232	58.00
60.00	06000	LABORATORY	304	2,472	287	1,970	1,599	60.00
64.00	06400	INTRAVENOUS THERAPY	155	1,001	337	799	300	64.00
65.00	06500	RESPIRATORY THERAPY	177	986	159	786	399	65.00
66.00	06600	PHYSICAL THERAPY	229	1,203	6,308	1,011	140	66.00
67.00	06700	OCCUPATIONAL THERAPY	51	263	0	209	12	67.00
68.00	06800	SPEECH PATHOLOGY	29	91	361	76	3	68.00
69.00	06900	ELECTROCARDIOLOGY	45	251	126	201	110	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17	302	72	241	12	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102	4,054	6,927	3,285	295	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,110	7,684	20,658	0	1,974	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	464	3,544	0	2,820	934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,138	48,592	58,396	32,301	13,723	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	629	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107	1,016	0	0	68	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	8	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	1	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,245	49,608	58,404	32,301	14,421	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	747,604					5.05
7.00	00700	OPERATION OF PLANT	36,019	207,113				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,712	1,367	22,105			8.00
9.00	00900	HOUSEKEEPING	15,904	3,156	0	62,019		9.00
10.00	01000	DIETARY	7,171	7,849	0	548	117,851	10.00
11.00	01100	CAFETERIA	9,598	3,098	0	1,520	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,251	1,024	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,782	2,559	0	442	0	16.00
17.00	01700	SOCIAL SERVICE	5,667	862	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,787	44,068	6,230	14,338	108,229	30.00
31.00	03100	INTENSIVE CARE UNIT	4,486	6,675	43	902	437	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,814	12,609	2,352	7,461	0	50.00
51.00	05100	RECOVERY ROOM	16,751	14,146	1,076	1,326	2,319	51.00
53.00	05300	ANESTHESIOLOGY	1,432	372	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,258	11,031	1,682	3,235	0	54.00
56.00	05600	RADIOISOTOPE	8,343	1,982	302	583	0	56.00
57.00	05700	CT SCAN	9,257	1,336	204	389	0	57.00
58.00	05800	MRI	5,621	2,991	456	884	0	58.00
60.00	06000	LABORATORY	48,153	5,475	0	2,086	0	60.00
64.00	06400	INTRAVENOUS THERAPY	19,361	12,958	0	2,528	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,085	6,245	287	1,821	0	65.00
66.00	06600	PHYSICAL THERAPY	24,365	6,040	2,136	1,680	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,033	1,416	491	389	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,816	291	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,888	294	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,785	8,068	10	354	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,090	2,282	0	548	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	151,921	22,156	274	9,777	1,701	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	68,238	14,273	6,557	6,152	5,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	725,588	194,623	22,100	56,963	117,851	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,779	698	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,428	11,452	5	5,056	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	68	170	0	0	0	194.01
194.02	07952	FOUNDATION	741	170	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	747,604	207,113	22,105	62,019	117,851	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	55,222					11.00
13.00	01300	NURSING ADMINISTRATION	144	22,333				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,109	0	58,955			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	18,502		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,048	7,239	20,754	16,115	879,446	30.00
31.00	03100	INTENSIVE CARE UNIT	117	84	29	0	100,669	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,354	1,695	0	0	230,460	50.00
51.00	05100	RECOVERY ROOM	1,758	1,268	4,048	0	229,048	51.00
53.00	05300	ANESTHESIOLOGY	782	0	0	0	8,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,910	2,097	2,765	0	221,656	54.00
56.00	05600	RADIOISOTOPE	19	14	485	0	38,070	56.00
57.00	05700	CT SCAN	1,097	791	342	0	31,879	57.00
58.00	05800	MRI	514	371	741	0	50,947	58.00
60.00	06000	LABORATORY	4,937	3,557	1,996	0	143,444	60.00
64.00	06400	INTRAVENOUS THERAPY	2,377	0	0	0	206,924	64.00
65.00	06500	RESPIRATORY THERAPY	2,859	0	2,081	0	115,426	65.00
66.00	06600	PHYSICAL THERAPY	2,684	0	2,281	0	125,977	66.00
67.00	06700	OCCUPATIONAL THERAPY	591	0	228	0	26,949	67.00
68.00	06800	SPEECH PATHOLOGY	397	0	86	0	6,908	68.00
69.00	06900	ELECTROCARDIOLOGY	276	198	342	0	10,526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	638	0	0	0	119,550	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,011	727	0	0	127,747	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,617	0	4,048	358	518,021	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,960	4,292	15,451	2,029	319,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,199	22,333	55,677	18,502	3,511,781	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	12,109	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,023	0	3,278	0	189,249	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	2,441	194.01
194.02	07952	FOUNDATION	0	0	0	0	3,107	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	55,222	22,333	58,955	18,502	3,718,687	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01140	BUSINESS OFFICE				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00570	ADMITTING				5.03
5.04	00560	PURCHASING RECEIVING AND STORES				5.04
5.05	00590	OTHER A&G				5.05
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	879,446		30.00
31.00	03100	INTENSIVE CARE UNIT	0	100,669		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	230,460		50.00
51.00	05100	RECOVERY ROOM	0	229,048		51.00
53.00	05300	ANESTHESIOLOGY	0	8,183		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	221,656		54.00
56.00	05600	RADIOISOTOPE	0	38,070		56.00
57.00	05700	CT SCAN	0	31,879		57.00
58.00	05800	MRI	0	50,947		58.00
60.00	06000	LABORATORY	0	143,444		60.00
64.00	06400	INTRAVENOUS THERAPY	0	206,924		64.00
65.00	06500	RESPIRATORY THERAPY	0	115,426		65.00
66.00	06600	PHYSICAL THERAPY	0	125,977		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,949		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,908		68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,526		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	119,550		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	127,747		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	518,021		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	319,951		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,511,781		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,109		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	189,249		192.00
194.00	07950	OTHER NRCC	0	0		194.00
194.01	07951	MARKETING	0	2,441		194.01
194.02	07952	FOUNDATION	0	3,107		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,718,687		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,958					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			99,958			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	11,459,898		4.00
5.01	01140	BUSINESS OFFICE	1,330	0	1,330	283,120	-599,234	5.01
5.02	00550	DATA PROCESSING	1,553	0	1,553	0	0	5.02
5.03	00570	ADMITTING	820	0	820	0	0	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	364	106,540	0	5.04
5.05	00590	OTHER A&G	19,467	0	19,467	981,463	0	5.05
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	294,835	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	0	8.00
9.00	00900	HOUSEKEEPING	1,094	0	1,094	338,144	0	9.00
10.00	01000	DIETARY	2,721	0	2,721	73,846	0	10.00
11.00	01100	CAFETERIA	1,074	0	1,074	205,922	0	11.00
13.00	01300	NURSING ADMINISTRATION	355	0	355	59,799	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	256,907	0	16.00
17.00	01700	SOCIAL SERVICE	299	0	299	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	1,329,886	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	24,059	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,371	0	4,371	373,410	0	50.00
51.00	05100	RECOVERY ROOM	4,904	0	4,904	252,200	0	51.00
53.00	05300	ANESTHESIOLOGY	129	0	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824	0	3,824	505,053	0	54.00
56.00	05600	RADIOISOTOPE	687	0	687	5,343	0	56.00
57.00	05700	CT SCAN	463	0	463	177,364	0	57.00
58.00	05800	MRI	1,037	0	1,037	92,536	0	58.00
60.00	06000	LABORATORY	1,898	0	1,898	664,495	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	338,382	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,165	0	2,165	386,314	0	65.00
66.00	06600	PHYSICAL THERAPY	2,094	0	2,094	500,539	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	491	0	491	111,199	0	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	101	62,790	0	68.00
69.00	06900	ELECTROCARDIOLOGY	102	0	102	99,290	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,797	0	2,797	36,748	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	222,454	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,681	0	7,681	2,430,336	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,948	0	4,948	1,013,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,628	0	95,628	11,226,633	-599,234	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242	0	242	0	-47,891	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,970	100	3,970	233,265	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	59	0	59	0	-2,195	194.01
194.02	07952	FOUNDATION	59	0	59	0	-24,400	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,423,272	128	1,295,287	3,033,376		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	24.242902	1.280000	12.958312	0.264695		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				5,245		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000458		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HOURS)	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE	30,600,518					5.01
5.02	00550	DATA PROCESSING	389,019	72,894				5.02
5.03	00570	ADMITTING	30,505	2,180	-42,964	25,544,066		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	240,543	162	0	246,134	891,848	5.04
5.05	00590	OTHER A&G	6,464,901	4,653	0	6,616,831	24,204	5.05
7.00	00700	OPERATION OF PLANT	1,152,806	530	0	1,178,264	24,823	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,094	0	0	86,760	8,949	8.00
9.00	00900	HOUSEKEEPING	504,100	192	0	515,016	29,943	9.00
10.00	01000	DIETARY	226,804	180	0	232,224	13,480	10.00
11.00	01100	CAFETERIA	308,731	0	0	314,777	3,693	11.00
13.00	01300	NURSING ADMINISTRATION	234,004	0	0	238,586	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	366,850	8,487	0	420,214	1,273	16.00
17.00	01700	SOCIAL SERVICE	180,715	394	0	186,398	219	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,392,079	957	0	2,444,128	59,905	30.00
31.00	03100	INTENSIVE CARE UNIT	135,278	1,720	0	147,286	1,113	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	981,793	1,911	0	1,011,416	247,247	50.00
51.00	05100	RECOVERY ROOM	523,344	2,560	0	547,522	13,177	51.00
53.00	05300	ANESTHESIOLOGY	38,857	500	0	42,339	17,346	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,496,233	4,320	0	1,549,038	21,197	54.00
56.00	05600	RADIOISOTOPE	269,215	0	0	274,487	0	56.00
57.00	05700	CT SCAN	295,021	160	0	301,669	10,528	57.00
58.00	05800	MRI	177,489	0	0	180,965	14,377	58.00
60.00	06000	LABORATORY	1,525,233	358	0	1,557,048	98,916	60.00
64.00	06400	INTRAVENOUS THERAPY	617,531	420	0	631,908	18,541	64.00
65.00	06500	RESPIRATORY THERAPY	608,128	199	0	621,119	24,698	65.00
66.00	06600	PHYSICAL THERAPY	741,920	7,873	0	799,287	8,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,228	0	0	165,405	720	67.00
68.00	06800	SPEECH PATHOLOGY	56,150	450	0	59,699	164	68.00
69.00	06900	ELECTROCARDIOLOGY	155,056	157	0	158,946	6,806	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,006	90	0	190,138	723	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,501,189	8,646	0	2,597,212	18,226	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,740,407	25,785	-4,973,539	0	122,058	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,186,435	0	0	2,229,250	57,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,973,664	72,884	-5,016,503	25,544,066	848,721	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-47,891	0	38,888	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	626,854	0	-639,129	0	4,191	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	10	-2,249	0	0	194.01
194.02	07952	FOUNDATION	0	0	-24,400	0	48	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	599,234	396,637		42,964	246,548	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019582	5.441285		0.001682	0.276446	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,608	58,404		32,301	14,421	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001621	0.801218		0.001265	0.016170	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	Reconciliation	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A.05	5.05	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G	-6,634,651	24,639,587				5.05
7.00	00700	OPERATION OF PLANT	0	1,187,108	71,800			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,380	474	100,627		8.00
9.00	00900	HOUSEKEEPING	0	524,160	1,094	0	3,508	9.00
10.00	01000	DIETARY	0	236,341	2,721	0	31	10.00
11.00	01100	CAFETERIA	0	316,327	1,074	0	86	11.00
13.00	01300	NURSING ADMINISTRATION	0	238,987	355	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	421,273	887	0	25	16.00
17.00	01700	SOCIAL SERVICE	0	186,773	299	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,464,799	15,277	28,361	811	30.00
31.00	03100	INTENSIVE CARE UNIT	0	147,842	2,314	194	51	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,081,468	4,371	10,705	422	50.00
51.00	05100	RECOVERY ROOM	0	552,086	4,904	4,899	75	51.00
53.00	05300	ANESTHESIOLOGY	0	47,205	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,557,503	3,824	7,657	183	54.00
56.00	05600	RADIOISOTOPE	0	274,949	687	1,376	33	56.00
57.00	05700	CT SCAN	0	305,086	463	927	22	57.00
58.00	05800	MRI	0	185,243	1,037	2,076	50	58.00
60.00	06000	LABORATORY	0	1,587,012	1,898	0	118	60.00
64.00	06400	INTRAVENOUS THERAPY	0	638,097	4,492	0	143	64.00
65.00	06500	RESPIRATORY THERAPY	0	628,992	2,165	1,307	103	65.00
66.00	06600	PHYSICAL THERAPY	0	803,024	2,094	9,722	95	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	165,882	491	2,236	22	67.00
68.00	06800	SPEECH PATHOLOGY	0	59,844	101	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	161,094	102	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	190,658	2,797	45	20	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,606,620	791	0	31	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,007,281	7,681	1,248	553	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,248,962	4,948	29,852	348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,634,651	23,913,996	67,470	100,605	3,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,641	242	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	640,288	3,970	22	286	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	2,249	59	0	0	194.01
194.02	07952	FOUNDATION	0	24,413	59	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		6,634,651	1,506,758	123,394	688,258	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.269268	20.985487	1.226251	196.196693	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		747,604	207,113	22,105	62,019	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.030342	2.884582	0.219673	17.679304	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 11:30 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	7,827					10.00
11.00	01100	CAFETERIA	0	14,195				11.00
13.00	01300	NURSING ADMINISTRATION	0	37	165,779			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	542	0	2,068		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	465	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,188	2,583	53,736	728	405	30.00
31.00	03100	INTENSIVE CARE UNIT	29	30	622	1	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	605	12,583	0	0	50.00
51.00	05100	RECOVERY ROOM	154	452	9,409	142	0	51.00
53.00	05300	ANESTHESIOLOGY	0	201	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	748	15,566	97	0	54.00
56.00	05600	RADIOISOTOPE	0	5	107	17	0	56.00
57.00	05700	CT SCAN	0	282	5,868	12	0	57.00
58.00	05800	MRI	0	132	2,754	26	0	58.00
60.00	06000	LABORATORY	0	1,269	26,403	70	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	611	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	735	0	73	0	65.00
66.00	06600	PHYSICAL THERAPY	0	690	0	80	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	152	0	8	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	102	0	3	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	71	1,471	12	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	164	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	260	5,399	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	113	2,729	0	142	9	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	343	1,532	31,861	542	51	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,827	13,932	165,779	1,953	465	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	263	0	115	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	363,164	440,915	311,938	575,062	243,340	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	46.398876	31.061289	1.881650	278.076402	523.311828	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	117,851	55,222	22,333	58,955	18,502	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	15.056982	3.890243	0.134715	28.508221	39.789247	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,572,219		4,572,219	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	250,181		250,181	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,602,792		1,602,792	0	0	50.00
51.00	05100	RECOVERY ROOM	902,756		902,756	0	0	51.00
53.00	05300	ANESTHESIOLOGY	68,866		68,866	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,181,928		2,181,928	0	0	54.00
56.00	05600	RADIOISOTOPE	376,645		376,645	0	0	56.00
57.00	05700	CT SCAN	425,543		425,543	0	0	57.00
58.00	05800	MRI	285,753		285,753	0	0	58.00
60.00	06000	LABORATORY	2,185,888		2,185,888	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	951,217		951,217	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	908,734	0	908,734	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,137,436	0	1,137,436	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,857	0	234,857	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	82,080	0	82,080	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	214,922		214,922	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	309,765		309,765	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,349,416		3,349,416	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,761,006		6,761,006	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,364,111		3,364,111	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	850,122		850,122		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	31,016,237	0	31,016,237	0	0	200.00
201.00		Less Observation Beds	850,122		850,122		0	201.00
202.00		Total (see instructions)	30,166,115	0	30,166,115	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,497,268		2,497,268			30.00
31.00	03100	INTENSIVE CARE UNIT	19,034		19,034			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	420,583	4,097,053	4,517,636	0.354786	0.000000	50.00
51.00	05100	RECOVERY ROOM	21,657	1,221,368	1,243,025	0.726257	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	214,474	1,955,039	2,169,513	0.031743	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	252,114	4,451,692	4,703,806	0.463864	0.000000	54.00
56.00	05600	RADIOISOTOPE	42,701	1,101,120	1,143,821	0.329287	0.000000	56.00
57.00	05700	CT SCAN	534,038	9,172,043	9,706,081	0.043843	0.000000	57.00
58.00	05800	MRI	49,972	2,738,561	2,788,533	0.102474	0.000000	58.00
60.00	06000	LABORATORY	1,045,862	10,567,519	11,613,381	0.188222	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	528	681,245	681,773	1.395211	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	701,412	456,206	1,157,618	0.785003	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	299,140	2,330,343	2,629,483	0.432570	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,641	548,230	604,871	0.388276	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	13,898	204,509	218,407	0.375812	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	243,455	2,809,481	3,052,936	0.070398	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,231,324	440,175	1,671,499	0.185322	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,545,188	7,627,275	9,172,463	0.365160	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,342,789	4,342,789			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	160,144	5,324,964	5,485,108	0.613317	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	60,713	552,693	613,406	1.385904	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	9,410,146	60,622,305	70,032,451			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	9,410,146	60,622,305	70,032,451			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230,460	4,517,636	0.051013	187,459	9,563	50.00
51.00	05100	RECOVERY ROOM	229,048	1,243,025	0.184267	11,450	2,110	51.00
53.00	05300	ANESTHESIOLOGY	8,183	2,169,513	0.003772	92,800	350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	221,656	4,703,806	0.047123	104,968	4,946	54.00
56.00	05600	RADIOISOTOPE	38,070	1,143,821	0.033283	28,758	957	56.00
57.00	05700	CT SCAN	31,879	9,706,081	0.003284	124,844	410	57.00
58.00	05800	MRI	50,947	2,788,533	0.018270	29,184	533	58.00
60.00	06000	LABORATORY	143,444	11,613,381	0.012352	410,778	5,074	60.00
64.00	06400	INTRAVENOUS THERAPY	206,924	681,773	0.303509	18	5	64.00
65.00	06500	RESPIRATORY THERAPY	115,426	1,157,618	0.099710	265,961	26,519	65.00
66.00	06600	PHYSICAL THERAPY	125,977	2,629,483	0.047909	48,288	2,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,949	604,871	0.044553	5,385	240	67.00
68.00	06800	SPEECH PATHOLOGY	6,908	218,407	0.031629	4,593	145	68.00
69.00	06900	ELECTROCARDIOLOGY	10,526	3,052,936	0.003448	144,197	497	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	119,550	1,671,499	0.071523	671,491	48,027	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,747	9,172,463	0.013927	585,618	8,156	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	518,021	4,342,789	0.119283	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	319,951	5,485,108	0.058331	1,212	71	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	163,518	613,406	0.266574	17,209	4,587	92.00
200.00		Total (lines 50 through 199)	2,695,184	67,516,149		2,734,213	114,503	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,517,636	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,243,025	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,169,513	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,703,806	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	1,143,821	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	9,706,081	0.000000	57.00
58.00	05800	MRI	0	0	0	2,788,533	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,613,381	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	681,773	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,157,618	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,629,483	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	604,871	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	218,407	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,052,936	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,671,499	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,172,463	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,342,789	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	5,485,108	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	613,406	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	67,516,149		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	187,459	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	11,450	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	92,800	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	104,968	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	28,758	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	124,844	0	0	0	57.00
58.00	05800	MRI	0.000000	29,184	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	410,778	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	18	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	265,961	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	48,288	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	5,385	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	4,593	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	144,197	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	671,491	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	585,618	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,212	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	17,209	0	0	0	92.00
200.00		Total (lines 50 through 199)		2,734,213	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.354786	0	1,562,781	0	0	50.00
51.00	05100	RECOVERY ROOM	0.726257	0	469,093	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.031743	0	725,464	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.463864	0	1,403,771	0	0	54.00
56.00	05600	RADIOISOTOPE	0.329287	0	527,842	0	0	56.00
57.00	05700	CT SCAN	0.043843	0	3,684,169	0	0	57.00
58.00	05800	MRI	0.102474	0	887,973	0	0	58.00
60.00	06000	LABORATORY	0.188222	0	4,129,558	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.395211	0	452,769	2,885	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.785003	0	233,178	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.432570	0	875,513	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388276	0	76,799	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.375812	0	15,588	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070398	0	1,212,679	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.185322	0	128,955	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.365160	0	3,098,253	35,889	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.613317	0	1,611,093	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.385904	0	274,253	0	0	92.00
200.00		Subtotal (see instructions)		0	21,369,731	38,774	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	21,369,731	38,774	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	554,453	0		50.00
51.00	05100	RECOVERY ROOM	340,682	0		51.00
53.00	05300	ANESTHESIOLOGY	23,028	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	651,159	0		54.00
56.00	05600	RADIOISOTOPE	173,812	0		56.00
57.00	05700	CT SCAN	161,525	0		57.00
58.00	05800	MRI	90,994	0		58.00
60.00	06000	LABORATORY	777,274	0		60.00
64.00	06400	INTRAVENOUS THERAPY	631,708	4,025		64.00
65.00	06500	RESPIRATORY THERAPY	183,045	0		65.00
66.00	06600	PHYSICAL THERAPY	378,721	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	29,819	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,858	0		68.00
69.00	06900	ELECTROCARDIOLOGY	85,370	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,898	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,131,358	13,105		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	988,111	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	380,088	0		92.00
200.00		Subtotal (see instructions)	6,610,903	17,130		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,610,903	17,130		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.354786	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.726257	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.031743	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.463864	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.329287	0	0	0	0	56.00
57.00	05700	CT SCAN	0.043843	0	0	0	0	57.00
58.00	05800	MRI	0.102474	0	0	0	0	58.00
60.00	06000	LABORATORY	0.188222	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.395211	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.785003	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.432570	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388276	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.375812	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070398	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.185322	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.365160	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.613317	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.385904	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,648	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,572	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,097	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	244	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	730	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	26	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	76	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	703	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	180	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	540	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	150.15	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	153.39	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,572,219	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	3,904	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	11,658	25.00
26.00	Total swing-bed cost (see instructions)	1,758,759	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,813,460	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,813,460	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,789.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,258,180	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,258,180	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	250,181	14	17,870.07	4	71,480	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	828,253	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,157,913	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	322,151	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	966,454	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,288,605	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	475	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,789.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	850,122	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	879,446	4,572,219	0.192346	850,122	163,518	90.00
91.00	Nursing School cost	0	4,572,219	0.000000	850,122	0	91.00
92.00	Allied health cost	0	4,572,219	0.000000	850,122	0	92.00
93.00	All other Medical Education	0	4,572,219	0.000000	850,122	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		763,824		30.00
31.00	03100	INTENSIVE CARE UNIT		7,932		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.354786	187,459	66,508	50.00
51.00	05100	RECOVERY ROOM	0.726257	11,450	8,316	51.00
53.00	05300	ANESTHESIOLOGY	0.031743	92,800	2,946	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.463864	104,968	48,691	54.00
56.00	05600	RADIOISOTOPE	0.329287	28,758	9,470	56.00
57.00	05700	CT SCAN	0.043843	124,844	5,474	57.00
58.00	05800	MRI	0.102474	29,184	2,991	58.00
60.00	06000	LABORATORY	0.188222	410,778	77,317	60.00
64.00	06400	INTRAVENOUS THERAPY	1.395211	18	25	64.00
65.00	06500	RESPIRATORY THERAPY	0.785003	265,961	208,780	65.00
66.00	06600	PHYSICAL THERAPY	0.432570	48,288	20,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388276	5,385	2,091	67.00
68.00	06800	SPEECH PATHOLOGY	0.375812	4,593	1,726	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070398	144,197	10,151	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.185322	671,491	124,442	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.365160	585,618	213,844	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.613317	1,212	743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.385904	17,209	23,850	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,734,213	828,253	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		2,734,213		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.354786	0	0	50.00
51.00	05100	RECOVERY ROOM	0.726257	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.031743	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.463864	34,026	15,783	54.00
56.00	05600	RADIOISOTOPE	0.329287	6,287	2,070	56.00
57.00	05700	CT SCAN	0.043843	31,137	1,365	57.00
58.00	05800	MRI	0.102474	0	0	58.00
60.00	06000	LABORATORY	0.188222	156,696	29,494	60.00
64.00	06400	INTRAVENOUS THERAPY	1.395211	21	29	64.00
65.00	06500	RESPIRATORY THERAPY	0.785003	160,362	125,885	65.00
66.00	06600	PHYSICAL THERAPY	0.432570	156,874	67,859	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.388276	35,689	13,857	67.00
68.00	06800	SPEECH PATHOLOGY	0.375812	8,489	3,190	68.00
69.00	06900	ELECTROCARDIOLOGY	0.070398	7,444	524	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.185322	173,184	32,095	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.365160	351,170	128,233	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.613317	623	382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.385904	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,122,002	420,766	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,122,002		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1310	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 11:30 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,628,033	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,628,033	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (see instructions)	6,694,313	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	39,424	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,446,938	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,207,951	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,207,951	30.00
31.00	Primary payer payments	322	31.00
32.00	Subtotal (line 30 minus line 31)	3,207,629	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	652,323	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	424,010	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	349,695	36.00
37.00	Subtotal (see instructions)	3,631,639	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,631,639	40.00
40.01	Sequestration adjustment (see instructions)	72,633	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,466,988	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-907,982	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,338,459		4,513,407	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/11/2017	90,165		0	3.01
3.02		09/28/2017	18,512		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	05/11/2017	46,419	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		108,677		-46,419	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,447,136		4,466,988	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		488,626		907,982	6.02
7.00	Total Medicare program liability (see instructions)		1,958,510		3,559,006	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,727,819		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/11/2017	113,150		0	3.01
3.02		09/28/2017	42,477		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		155,627		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,883,446		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		200,302		0	6.02
7.00	Total Medicare program liability (see instructions)		1,683,144		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1310	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/26/2018 11:30 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1310 | Component CCN: 14-Z310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/26/2018 11:30 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,301,491	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	424,974	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	720	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,726,465	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,726,465	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,726,465	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,971	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,717,494	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,717,494	0	19.00
19.01	Sequestration adjustment (see instructions)	34,350	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,883,446	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-200,302	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1310	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part V Date/Time Prepared: 2/26/2018 11:30 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,157,913	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,157,913	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,179,492	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,179,492	19.00
20.00	Deductibles (exclude professional component)	211,904	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,967,588	22.00
23.00	Coinsurance	1,316	23.00
24.00	Subtotal (line 22 minus line 23)	1,966,272	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	49,551	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	32,208	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	24,928	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,998,480	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	1,998,480	30.00
30.01	Sequestration adjustment (see instructions)	39,970	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,447,136	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-488,626	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	216,493	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/26/2018 11:30 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,320,000	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,296,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	721,000	0	0	0	7.00
8.00	Prepaid expenses	97,000	0	0	0	8.00
9.00	Other current assets	343,000	0	0	0	9.00
10.00	Due from other funds	130,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,907,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,927,000	0	0	0	12.00
13.00	Land improvements	2,643,000	0	0	0	13.00
14.00	Accumulated depreciation	-2,078,000	0	0	0	14.00
15.00	Buildings	18,074,000	0	0	0	15.00
16.00	Accumulated depreciation	-8,460,000	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	16,260,000	0	0	0	23.00
24.00	Accumulated depreciation	-14,085,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	26,000	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,307,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	53,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	15,749,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,802,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,016,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,557,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,937,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	707,000	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,201,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,554,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	26,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,580,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,781,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,235,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	1,235,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,016,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/26/2018 11:30 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		2,128,311		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-968,874				2.00
3.00	Total (sum of line 1 and line 2)		1,159,437		0		3.00
4.00	NET INCOME ROUNDING	1		0		0	4.00
5.00	ROUNDING/EQUITY XFER	75,562		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		75,563		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,235,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,235,000		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	NET INCOME ROUNDING		0			4.00
5.00	ROUNDING/EQUITY XFER		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2018 11:30 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,540,704		1,540,704	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	865,886		865,886	5.00
6.00	Swing bed - NF	90,678		90,678	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,497,268		2,497,268	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	19,034		19,034	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	19,034		19,034	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,516,302		2,516,302	17.00
18.00	Ancillary services	6,672,987	50,401,859	57,074,846	18.00
19.00	Outpatient services	220,857	5,877,657	6,098,514	19.00
20.00	RURAL HEALTH CLINIC	0	4,342,789	4,342,789	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	172,027	5,074,563	5,246,590	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,582,173	65,696,868	75,279,041	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,969,689		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		33,969,689		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1310 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/26/2018 11:30 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	75,279,041	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,163,381	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,115,660	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	33,969,689	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-854,029	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	119,731	6.00
7.00	Income from investments	9,570	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	79,790	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,025	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	280	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	38,533	20.00
21.00	Rental of vending machines	1,614	21.00
22.00	Rental of hospital space	45,340	22.00
23.00	Governmental appropriations	32,792	23.00
24.00	OTHER INCOME	219,920	24.00
25.00	Total other income (sum of lines 6-24)	553,595	25.00
26.00	Total (line 5 plus line 25)	-300,434	26.00
27.00	EQUITY TRANSFER	668,440	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	668,440	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-968,874	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/26/2018 11:30 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,077,583	135,308	1,212,891	-240,582	972,309	1.00
2.00	Physician Assistant	148,989	0	148,989	0	148,989	2.00
3.00	Nurse Practitioner	346,997	0	346,997	-33,218	313,779	3.00
4.00	Visiting Nurse	1,976	734	2,710	0	2,710	4.00
5.00	Other Nurse	557,275	205,633	762,908	-51,741	711,167	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	384,554	141,944	526,498	-34,086	492,412	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,517,374	483,619	3,000,993	-359,627	2,641,366	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	285,541	285,541	-203,685	81,856	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	41,670	41,670	-3,489	38,181	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	327,211	327,211	-207,174	120,037	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,517,374	810,830	3,328,204	-566,801	2,761,403	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	48,799	48,799	-23,656	25,143	29.00
30.00	Administrative Costs	261,245	868,898	1,130,143	-52,150	1,077,993	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	261,245	917,697	1,178,942	-75,806	1,103,136	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,778,619	1,728,527	4,507,146	-642,607	3,864,539	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-1 | Date/Time Prepared: 2/26/2018 11:30 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-8,457	963,852		1.00
2.00	Physician Assistant	0	148,989		2.00
3.00	Nurse Practitioner	-184	313,595		3.00
4.00	Visiting Nurse	0	2,710		4.00
5.00	Other Nurse	0	711,167		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	492,412		9.00
10.00	Subtotal (sum of lines 1 through 9)	-8,641	2,632,725		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	81,856		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	38,181		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	120,037		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-8,641	2,752,762		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	25,143		29.00
30.00	Administrative Costs	-44,532	1,033,461		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-44,532	1,058,604		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-53,173	3,811,366		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1310 | Component CCN: 14-8535 | Period: From 10/01/2016 To 09/30/2017 | Worksheet M-2 | Date/Time Prepared: 2/26/2018 11:30 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.31	8,767	4,200	9,702		1.00
2.00	Physician Assistant	1.39	3,638	2,100	2,919		2.00
3.00	Nurse Practitioner	2.74	5,948	2,100	5,754		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.44	18,353		18,375	18,375	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.44	18,353			18,375	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,752,762	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,752,762	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,058,604	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,949,640	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,008,244	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,008,244	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,008,244	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,761,006	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2016 To 09/30/2017	Worksheet M-3 Date/Time Prepared: 2/26/2018 11:30 am
	Title XVIII	RHC I	Cost

			1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		6,761,006	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		317,847	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		6,443,159	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		18,375	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		18,375	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		350.65	7.00
		Calculation of Limit (1)		
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	81.32	82.30	8.00
9.00	Rate for Program covered visits (see instructions)	350.65	350.65	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,633	4,900	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	572,611	1,718,185	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	2,290,796	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,274,621	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		13,166	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		23,662	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,721,317	16.04
16.05	Total program cost (see instructions)	0	1,744,979	16.05
17.00	Primary payer amounts		126	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		115,488	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		229,187	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,744,853	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		181,887	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,926,740	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		1,926,740	26.00
26.01	Sequestration adjustment (see instructions)		38,535	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		704,950	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		1,183,255	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2016 To 09/30/2017	Worksheet M-4 Date/Time Prepared: 2/26/2018 11:30 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,632,725	2,632,725	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000747	0.000747	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,967	1,967	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	105,944	19,534	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	107,911	21,501	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2,752,762	2,752,762	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,008,244	4,008,244	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.039201	0.007811	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	157,127	31,308	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	265,038	52,809	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	902	1,266	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	293.83	41.71	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	555	451	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	163,076	18,811	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		317,847	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		181,887	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-1310 Component CCN: 14-8535	Period: From 10/01/2016 To 09/30/2017	Worksheet M-5 Date/Time Prepared: 2/26/2018 11:30 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		704,950	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		704,950	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,183,255	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,888,205	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00